		FOR OHF USE					

LL1

2003
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2003)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0027599

Facility Name: ManorCare at Peoria

Address: 5600 N. Glen Elm Dr. (Number) Peoria (City) 61614 (Zip Code)

County: Peoria

Telephone Number: (309) 693-8777 **Fax #** (309) 693-8794

IDPA ID Number: 520886946002

Date of Initial License for Current Owners: 11/1/81

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code		X	Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Craig Dekany **Telephone Number:** (419) 252-5740

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 6/1/02 to 5/31/03 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)
(Type or Print Name) Barry Lazarus
(Title) Vice President - Reimbursement

Paid Preparer

(Signed) _____ (Date)
(Print Name and Title)
(Firm Name & Address)
(Telephone) ( ) Fax # ( )

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number ManorCare at Peoria # 0027599 Report Period Beginning: 6/1/02 Ending: 5/31/03

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	144	Skilled (SNF)	144	52,560	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	144	TOTALS	144	52,560	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	849	638	9,288	10,775	8
9	SNF/PED					9
10	ICF	8,419	25,722	2,427	36,568	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	9,268	26,360	11,715	47,343	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 90.07%

D. How many bed-hold days during this year were paid by Public Aid?
47 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
N/A

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 11/01/81

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 11/01/81 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 37 and days of care provided 8,017

Medicare Intermediary CareFirst of Maryland, Inc.

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [ ] NO [X]

Tax Year: 12/31/03 Fiscal Year: 5/31/03

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number ManorCare at Peoria # 0027599 **Report Period Beginning:** 6/1/02 **Ending:** 5/31/03

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	A. General Services											
1	Dietary	221,921	21,417	8,203	251,541	2,077	253,618		253,618			1
2	Food Purchase		216,405		216,405		216,405	(1,943)	214,462			2
3	Housekeeping	145,328	18,242	2,196	165,766		165,766		165,766			3
4	Laundry	50,759	10,298	1,264	62,321		62,321		62,321			4
5	Heat and Other Utilities			165,119	165,119	8,461	173,580	(10,032)	163,548			5
6	Maintenance	43,040	8,261	40,137	91,438		91,438		91,438			6
7	Other (specify):*			3,034	3,034		3,034		3,034			7
8	**TOTAL General Services**	461,048	274,623	219,953	955,624	10,538	966,162	(11,975)	954,187			8
	B. Health Care and Programs											
9	Medical Director			7,500	7,500		7,500		7,500			9
10	Nursing and Medical Records	1,937,924	176,545	38,853	2,153,322	36,031	2,189,353		2,189,353			10
10a	Therapy	382,602	6,164	27,323	416,089		416,089		416,089			10a
11	Activities	71,312	5,450	3,760	80,522		80,522		80,522			11
12	Social Services	66,194	191	2,928	69,313		69,313		69,313			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	2,458,032	188,350	80,364	2,726,746	36,031	2,762,777		2,762,777			16
	C. General Administration											
17	Administrative	83,949		389,931	473,880	(187,920)	285,960		285,960			17
18	Directors Fees											18
19	Professional Services			1,352	1,352	(583)	769	(769)				19
20	Dues, Fees, Subscriptions & Promotions			61,030	61,030		61,030	(37,412)	23,618			20
21	Clerical & General Office Expenses	250,863	44,117	137,933	432,913		432,913	(132,672)	300,241			21
22	Employee Benefits & Payroll Taxes			661,225	661,225	64,813	726,038		726,038			22
23	Inservice Training & Education			1,312	1,312		1,312		1,312			23
24	Travel and Seminar			9,879	9,879		9,879		9,879			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			139,133	139,133		139,133		139,133			26
27	Other (specify):* P/S Admin.			44	44		44		44			27
28	**TOTAL General Administration**	334,812	44,117	1,401,839	1,780,768	(123,690)	1,657,078	(170,853)	1,486,225			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	3,253,892	507,090	1,702,156	5,463,138	(77,121)	5,386,017	(182,828)	5,203,189			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number ManorCare at Peoria #0027599 Report Period Beginning: 6/1/02 Ending: 5/31/03

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			437,647	437,647	40,981	478,628		478,628			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			36,452	36,452	36,140	72,592		72,592			32
33	Real Estate Taxes			78,530	78,530		78,530	4,584	83,114			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			52,062	52,062		52,062		52,062			35
36	Other (specify):*											36
37	**TOTAL Ownership**			604,691	604,691	77,121	681,812	4,584	686,396			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		208,357	6,727	215,084		215,084		215,084			39
40	Barber and Beauty Shops			11,439	11,439		11,439		11,439			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			78,841	78,841		78,841		78,841			42
43	Other (specify):*		25,458		25,458		25,458		25,458			43
44	**TOTAL Special Cost Centers**		233,815	97,007	330,822		330,822		330,822			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,253,892	740,905	2,403,854	6,398,651		6,398,651	(178,244)	6,220,407			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number ManorCare at Peoria # 0027599 Report Period Beginning: 6/1/02 Ending: 5/31/03

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(1,943)	2		4
5	Telephone, TV & Radio in Resident Rooms	(10,032)	5		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(3,319)	21		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(2,582)	21		13
14	Non-Care Related Interest	(254)	21		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)	(13,302)	21		16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(769)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(113,215)	21		24
25	Fund Raising, Advertising and Promotional	(37,412)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	4,584	33		26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (178,244)		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (178,244)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS **Page 5A**

ManorCare at Peoria

ID# **0027599**

Report Period Beginning: **6/1/02**

Ending: **5/31/03**

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1		$		1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	0		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number ManorCare at Peoria # 0027599 Report Period Beginning: 6/1/02 Ending: 5/31/03

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(1,943)	0	0	0	0	0	0	0	0	0	0	(1,943)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	(10,032)	0	0	0	0	0	0	0	0	0	0	(10,032)	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(11,975)	0	0	0	0	0	0	0	0	0	0	(11,975)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(769)	0	0	0	0	0	0	0	0	0	0	(769)	19
20	Fees, Subscriptions & Promotions	(37,412)	0	0	0	0	0	0	0	0	0	0	(37,412)	20
21	Clerical & General Office Expenses	(132,672)	0	0	0	0	0	0	0	0	0	0	(132,672)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(170,853)	0	0	0	0	0	0	0	0	0	0	(170,853)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(182,828)	0	0	0	0	0	0	0	0	0	0	(182,828)	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number ManorCare at Peoria **#** 0027599 **Report Period Beginning:** 6/1/02 **Ending:** 5/31/03

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	4,584	0	0	0	0	0	0	0	0	0	0	4,584	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	4,584	0	0	0	0	0	0	0	0	0	0	4,584	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(178,244)	0	0	0	0	0	0	0	0	0	0	(178,244)	45

Facility Name & ID Number ManorCare at Peoria # 0027599 Report Period Beginning: 6/1/02 Ending: 5/31/03

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Manor Care, Inc.	100	Health Care & Retirement Corporation of America (See H. O. Cost Report)	Toledo, OH			

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	See	Home Office Allocation	$ 389,931	HCR ManorCare, Inc.	100.00%	$ 389,931	$	1
2	V	Page							2
3	V	8							3
4	V								4
5	V								5
6	V	10a	Therapy Management	26,868	Heartland Management Services	100.00%	26,868		6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 416,799			$ 416,799	$ *	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number ManorCare at Peoria # 0027599 Report Period Beginning: 6/1/02 Ending: 5/31/03

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	N/A								$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number ManorCare at Peoria # 0027599 Report Period Beginning: 6/1/02 Ending: 5/31/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: HCR Manor Care, Inc.
Street Address: 333 North Summit Street
City / State / Zip Code: Toledo, Ohio 43604
Phone Number: ((419) 252-5500
Fax Number: ((419) 252-5495

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	Dietary - Direct	Accumulated Cost	2,276,617,075	357 Nurs. Fac	$	$	6,057,612	$ 0	1
2	1	Dietary - Pooled	Accumulated Cost	2,686,344,447	357 Nurs. Fac	920,912	536,824	6,057,612	2,077	2
3	5	Utilities - Direct	Accumulated Cost	2,276,617,075	357 Nurs. Fac	112,862		6,057,612	300	3
4	5	Utilities - Pooled	Accumulated Cost	2,686,344,447	357 Nurs. Fac	3,618,915		6,057,612	8,161	4
5	10	Nursing - Direct	Accumulated Cost	2,276,617,075	357 Nurs. Fac	11,131,912	7,408,777	6,057,612	29,620	5
6	10	Nursing - Pooled	Accumulated Cost	2,686,344,447	357 Nurs. Fac	2,842,925	1,812,855	6,057,612	6,411	6
7	17	General & Admin - Direct	Accumulated Cost	2,276,617,075	357 Nurs. Fac	19,326,083	15,188,841	6,057,612	51,423	7
8	17	General & Admin - Pooled	Accumulated Cost	2,686,344,447	357 Nurs. Fac	66,522,981	38,146,902	6,057,612	150,007	8
9	22	Employee Benefits - Direct	Accumulated Cost	2,276,617,075	357 Nurs. Fac	2,749,439		6,057,612	7,316	9
10	22	Employee Benefits - Pooled	Accumulated Cost	2,686,344,447	357 Nurs. Fac	25,498,075		6,057,612	57,497	10
11	30	Depreciation - Direct	Accumulated Cost	2,276,617,075	357 Nurs. Fac	148,355		6,057,612	395	11
12	30	Depreciation - Pooled	Accumulated Cost	2,686,344,447	357 Nurs. Fac	17,998,306		6,057,612	40,586	12
13										13
14										14
15	32	Interest				7,352,132			36,140	15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 158,222,897	$ 63,094,199		$ 389,933	25

Facility Name & ID Number ManorCare at Peoria # 0027599 Report Period Beginning: 6/1/02 Ending: 5/31/03

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	Conv. Sub Debentures		X	Facility			$ 897,108	$ 897,108		0.0403	$ 36,140	1
2	Bank of Amer./Nat'l. City						1,211,834	1,211,834			36,452	2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$ 2,108,942	$ 2,108,942			$ 72,592	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 2,108,942	$ 2,108,942			$ 72,592	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ N/A Line #

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number ManorCare at Peoria # 0027599 Report Period Beginning: 6/1/02 Ending: 5/31/03

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2002 report.	*Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$ 73,945	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$ 78,530	2
3. Under or (over) accrual (line 2 minus line 1).		$ 4,585	3
4. Real Estate Tax accrual used for 2003 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 78,530	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 83,114	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1998	61,904	8
	1999	55,883	9
	2000	68,083	10
	2001	71,014	11
	2002	78,530	12

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2002	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2002 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2002 real estate tax costs, as well as copies of your real estate tax bills for calendar 2002.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2002 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2003 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2002 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME ManorCare at Peoria COUNTY Peoria

FACILITY IDPH LICENSE NUMBER 0027599

CONTACT PERSON REGARDING THIS REPORT Craig Dekany

TELEPHONE (409) 252-5740 FAX #: (419) 252-5495

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2002 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2002.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	14-16-451-008	See Attached	$ 41,144.80	$ 41,144.80
2.	14-16-451-018	See Attached	$ 298.98	$ 298.98
3.	14-16-451-019	See Attached	$ 290.67	$ 290.67
4.	14-16-451-008	See Attached	$ 41,144.80	$ 41,144.80
5.	14-16-451-018	See Attached	$ 298.98	$ 298.98
6.	14-16-451-019	See Attached	$ 290.67	$ 290.67
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 83,468.90	$ 83,468.90

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? ____ YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2002 tax bills which were listed in Section A to this statement. Be sure to use the 2002 tax bill which is normally paid during 2003.

Facility Name & ID Number ManorCare at Peoria # 0027599 Report Period Beginning: 6/1/02 Ending: 5/31/03

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 31,772 B. General Construction Type: Exterior Masonry Frame Steel Number of Stories 1

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility		1981	$ 190,551	1
2	Facility		1998 & 2002	46,300	2
3	TOTALS			$ 236,851	3

Facility Name & ID Number ManorCare at Peoria # 0027599 Report Period Beginning: 6/1/02 Ending: 5/31/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	104			1963	$ 834,425	$ 129,570		$ 129,570	$	$ 1,402,973	4
5	10			1987	479,517						5
6	10			1992	711,949						6
7	10			1998	1,010,896						7
8	10			2002	826,182						8
	Improvement Type**										
9	Building Improvements (Current year Depreciation)					208,956		208,956		1,258,836	9
10				1978	65,310						10
11				1979	23,480						11
12				1981	63,642						12
13				1982	10,239						13
14				1983	6,057						14
15				1984	9,737						15
16				1985	9,518						16
17				1987	65,867						17
18				1988	15,166						18
19				1989	176,034						19
20				1990	35,994						20
21				1991	125,588						21
22				1992	134,218						22
23				1993	29,944						23
24				1994	78,083						24
25				1995	44,937						25
26	ELECTRICAL WORK			1995	5,075						26
27	CARPET			1995	5,237						27
28	PAINTING			1995	18,789						28
29	WALLVINYL			1995	7,203						29
30	CERAMIC TILE & INSTALLATION			1995	2,283						30
31	BATHROOM RENOVATION			1995	4,388						31
32	BATHROOM RENOVATIONS			1995	6,989						32
33	FIRE ALARMS/SMOKE DETECTORS			1995	689						33
34	HVAC WORK			1995	500						34
35	PAVING/REPAIRS			1995	1,425						35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number ManorCare at Peoria # 0027599 Report Period Beginning: 6/1/02 Ending: 5/31/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	CAPITALIZED LABOR-BATHROOMS	1996	$ 7,272	$		$	$	$	37
38	ROOF WORK	1996	1,374						38
39	HOLDING TANK/VALVES	1996	1,942						39
40	DOORS	1996	398						40
41	CARPET	1996	13,137						41
42	TILE	1996	2,036						42
43	WALLCOVERINGS	1996	11,574						43
44	INSTALL TWO BOILERS	1996	12,289						44
45	HERITAGE RENOVATIONS	1996	7,965						45
46	ELECTRICAL/LIGHTING	1996	1,611						46
47	INSTALL CABINETS	1996	12,758						47
48	HEATING/AC WORK	1996	3,759						48
49	EXIT DEVICES	1996	1,765						49
50	DOORS/SIGNS	1996	2,802						50
51	LIGHTING	1997	1,572						51
52	CARPET & INSTALLATION	1997	3,230						52
53	RETIREMENTS	1987	(33,597)						53
54	RETIREMENTS	1992	(18,859)						54
55	SIDING	1997	2,335						55
56	WALLCOVERINGS	1997	6,104						56
57	INSTALL EXHAUST FAN/LIGHT	1997	2,211						57
58	NITEL SX-200 SYSTEM	1997	23,641						58
59	PAGING SYSTEM	1997	5,333						59
60	ROOFTOP A/C	1997	10,968						60
61	CARPET	1997	829						61
62	CEILING WORK	1997	2,385						62
63	ROOF REPAIRS	1997	2,177						63
64	ALLOC FAC. PLAN-HERITAGE	1997	2,758						64
65	ELECTRIC	1997	2,687						65
66	WATER HEATER/WATER LINE	1997	1,166						66
67	FLOORING/CEILING	1998	3,448						67
68	CARPETING	1998	3,020						68
69									69
70	TOTAL (lines 4 thru 69)		$ 4,911,451	$ 338,526		$ 338,526	$	$ 2,661,809	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number ManorCare at Peoria # 0027599 Report Period Beginning: 6/1/02 Ending: 5/31/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 4,911,451	$ 338,526		$ 338,526	$	$ 2,661,809	1
2	PAINTING	1998	3,020						2
3	WALLCOVERINGS	1998	3,020						3
4	INSTALL HANDRAILS	1998	4,875						4
5	INSTALL DOORS/LOCKS	1998	2,820						5
6	CORPORATE OVERHEAD-HERITAGE ADDTN	1998	1,702						6
7	FINISH/STUD	1998	45,863						7
8	SITE/DEMOLITION	1998	86,230						8
9	LANDSCAPING	1998	5,310						9
10	ROOFING	1998	53,000						10
11	ELECTRICAL	1998	841						11
12	AIR CONDITIONING	1998	5,617						12
13	CARPETING	1998	1,994						13
14	GENERAL CONTRACTOR FEES-HERITAGE ADDTN	1998	2,524						14
15	PAINTING/WALLCOVERING	1998	531						15
16	PLUMBING	1998	7,900						16
17	SIGNAGE	1998	11,862						17
18	GAZEBO	1998	1,325						18
19	50 GAL AMTEK	1999	1,699						19
20	AIR CONDITIONING	1999	1,940						20
21	LAND IMPROVEMENTS-ARCADIA REN	1999	6,099						21
22	LAND IMPROVEMENTS-ARCADIA REN	1999	315						22
23	CONCRETE PAD	1999	713						23
24	EXIT DOOR ALARM	1999	547						24
25	RUSKIN PAMPER	1999	896						25
26	HOT WATER LINE	1999	780						26
27	FURNISHINGS	1999	557						27
28	SMOKING SHELTER	1999	4,950						28
29	BUILDING IMPROVEMENTS-ARCADIA	1999	1,821						29
30	BUILDING IMPROVEMENTS-ARCADIA	1999	780						30
31	LOCKS	1999	4,509						31
32	SMOKING SHELTER	1999	4,950						32
33									33
34	TOTAL (lines 1 thru 33)		$ 5,180,441	$ 338,526		$ 338,526	$	$ 2,661,809	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number ManorCare at Peoria # 0027599 Report Period Beginning: 6/1/02 Ending: 5/31/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 5,180,441	$ 338,526		$ 338,526	$	$ 2,661,809	1
2	RETENTION	1999	29,415						2
3	CAMERA SECURITY	1999	3,469						3
4	DOOR	1999	1,011						4
5	FLOOR	1999	774						5
6	ENGINEER/DESIGNER FEES-ARCADIA RENOV	1999	693						6
7	ELECTRICAL CONTRACT-ARCADIA RENOV	1999	450						7
8	PIPING	1999	2,730						8
9	HVAC	1999	1,034						9
10	SECURITY SYSTEM - SECOND HALF	2000	3,468						10
11	FLOOR TILE - RESIDENT ROOM	2000	3,870						11
12	POWERS VALVE	2000	670						12
13	SECURE CARE	2000	1,019						13
14	A/C DUCTLESS SYSTEM	2001	3,774						14
15	VCT - DINING ROOM	2001	4,168						15
16	PAINTING / RETAINAGE	2001	98						16
17	PAINTING	2001	882						17
18	PAINTING	2001	1,000						18
19	GENERAL OVERHEAD-MEDICARE RENOV	2001	57,004						19
20	DRAPES,SHADES, BLINDS	2001	10,662						20
21	CEILING, KICKERBOARD-MEDICARE RENOV	2001	31,746						21
22	CARPET, PAINT, WALLPAPER-MEDICARE RENOV	2001	59,734						22
23	HAVAC AND ELECTRICAL	2001	7,683						23
24	PAINT, WALLPAPER	2001	3,470						24
25	DRYWALL,DOOR, CARPENTRY-ARCADIA RENOV	2001	34,121						25
26	WALLPAPER, CARPET-ARCADIA RENOV	2001	58,729						26
27	PAINTING-ARCADIA RENOV	2001	12,554						27
28	PLUMBING, ELECTRICAL-ARCAIDA RENOV	2001	107,746						28
29	GENERAL OVERHEAD-ARCADIA RENOV	2001	150,192						29
30	DRAPES,ARTWORK-ARCADIA RENOV	2001	21,753						30
31	WALLS, FLOOR, DOOR FOR LAUNDRY	2001	9,000						31
32	WALLS,FLOOR,DOOR FOR LAUNDRY RM	2001	4,250						32
33									33
34	TOTAL (lines 1 thru 33)		$ 5,807,610	$ 338,526		$ 338,526	$	$ 2,661,809	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number ManorCare at Peoria # 0027599 Report Period Beginning: 6/1/02 Ending: 5/31/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 5,807,610	$ 338,526		$ 338,526	$	$ 2,661,809	1
2	FLOORING	2001	18,030						2
3	FLOORING	2002	1,052						3
4	CARPET, VINYL WALL COVERING	2001	11,143						4
5	ROOF	2001	184,141						5
6	SOIL/CONCRETE TEST, FEES	2001	15,756						6
7	GC-SITEWORK	2001	269,327						7
8	C/R 5/31/99 AUDIT ADJ - CAPITAL LABOR	1996	(7,272)						8
9	C/R 5/31/99 AUDIT ADJ - ALLOC FAC PLAN	1997	(2,758)						9
10	C/R 5/31/99 AUDIT ADJ - CORPORATE OVERHEAD	1998	(1,702)						10
11	VWC, FLOORING	2002	8,790						11
12	CABINETS	2002	9,529						12
13	ADD'L CONSTRUCTION COST	2002	117						13
14	ADD'L CONSTRUCTION COST	2002	560						14
15	ADD'L CONSTRUCTION COST	2002	109						15
16	WINDOW TREATMENTS	2002	7,067						16
17	ROOFING	2002	1,486						17
18	ADDTN COSTS OF ARCADIA RE	2002	1,274						18
19	ADDTN COSTS OF ARCADIA RE	2002	2,867						19
20	VCT FLOORING	2002	1,484						20
21	VCT FLOORING	2002	1,367						21
22	VCT FLOORING	2002	1,192						22
23	RETAINAGE ON NEW CONSTRUCTION	2002	5,000						23
24	VWC	2002	1,182						24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 6,337,353	$ 338,526		$ 338,526	$	$ 2,661,809	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number ManorCare at Peoria # 0027599 Report Period Beginning: 6/1/02 Ending: 5/31/03

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 1,156,337	$ 99,121	$ 99,121	$		$ 786,028	71
72	Current Year Purchases	94,916						72
73	Fully Depreciated Assets							73
74	Home Office Allocation			40,981	40,981			74
75	TOTALS	$ 1,251,253	$ 99,121	$ 140,102	$ 40,981		$ 786,028	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 7,825,457	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 437,647	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 478,628	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 40,981	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 3,447,837	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. [ ] YES [ ] NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:	N/A			$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: [ ] YES [ ] NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2004	$
13.	/2005	$
14.	/2006	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [X] YES [ ] NO

16. Rental Amount for movable equipment: $ 52,062 Description: O2 Concentrators, Wheelchairs, Gerichairs, Elect. Beds., Etc.
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	N/A		$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number ManorCare at Peoria # 0027599 Report Period Beginning: 6/1/02 Ending: 5/31/03

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10a	hrs	$ 151,821	419	$ 10,486	$	419	$ 162,307	1
2	Licensed Speech and Language Development Therapist	10a	hrs	60,843	145	3,620		145	64,463	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a	hrs	169,938	523	13,083		523	183,021	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39, 2	# of prescrpts				208,357		208,357	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): P/S X-Ray & Lab	39,3				6,727			6,727	13
14	TOTAL			$ 382,602	1,087	$ 33,916	$ 208,357	1,087	$ 624,875	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

STATE OF ILLINOIS

Facility Name & ID Number ManorCare at Peoria **#** 0027599 **Report Period Beginning:** 6/1/02 **Ending:** 5/31/03

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 5/31/03 **(last day of reporting year)**

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ (59,949)	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (180,734))	714,557		3
4	Supply Inventory (priced at)	10,271		4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	4,305		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 669,184	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	236,851		13
14	Buildings, at Historical Cost	6,337,354		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,251,253		16
17	Accumulated Depreciation (book methods)	(3,447,837)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): CIP	140,791		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 4,518,412	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 5,187,596	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 46,458	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	310,855		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	78,530		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Accrued Liabilities	56,241		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 492,084	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	1,211,834		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 1,211,834	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,703,918	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 3,483,678	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 5,187,596	$	48

***(See instructions.)**

Facility Name & ID Number ManorCare at Peoria # 0027599 Report Period Beginning: 6/1/02 Ending: 5/31/03

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 3,802,457	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 3,802,457	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,837,919	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 1,837,919	17
	B. Transfers (Itemize):		
18	**Change in Interdivision**	(2,156,698)	18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$ (2,156,698)	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 3,483,678	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number ManorCare at Peoria # 0027599 Report Period Beginning: 6/1/02 Ending: 5/31/03

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 7,809,031	1
2	Discounts and Allowances for all Levels	(1,586,237)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 6,222,794	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,709,026	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,709,026	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop	1,606	12
13	Barber and Beauty Care	12,112	13
14	Non-Patient Meals	337	14
15	Telephone, Television and Radio	3	15
16	Rental of Facility Space		16
17	Sale of Drugs	242,300	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	37,271	19
20	Radiology and X-Ray	5,565	20
21	Other Medical Services	1,982	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 301,176	23
	D. Non-Operating Revenue		
24	Contributions	146	24
25	Interest and Other Investment Income***	254	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 400	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscellaneous Income	3,174	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 3,174	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 8,236,570	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	955,624	31
32	Health Care	2,726,746	32
33	General Administration	1,780,768	33
	B. Capital Expense		
34	Ownership	604,691	34
	C. Ancillary Expense		
35	Special Cost Centers	330,822	35
36	Provider Participation Fee		36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 6,398,651	40
41	**Income before Income Taxes (line 30 minus line 40)****	1,837,919	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 1,837,919	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number ManorCare at Peoria # 0027599 Report Period Beginning: 6/1/02 Ending: 5/31/03

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	3,066	3,252	$ 92,608	$ 28.48	1
2	Assistant Director of Nursing	1,889	2,003	46,355	23.14	2
3	Registered Nurses	11,038	11,706	265,957	22.72	3
4	Licensed Practical Nurses	21,328	22,619	406,491	17.97	4
5	Nurse Aides & Orderlies	104,924	111,278	1,097,186	9.86	5
6	Nurse Aide Trainees					6
7	Licensed Therapist	5,238	5,569	172,943	31.05	7
8	Rehab/Therapy Aides	9,863	10,487	209,659	19.99	8
9	Activity Director	7,159	7,592	71,312	9.39	9
10	Activity Assistants					10
11	Social Service Workers	5,966	6,323	92,310	14.60	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	23,225	24,617	221,921	9.01	15
16	Dishwashers					16
17	Maintenance Workers	2,271	2,402	43,040	17.92	17
18	Housekeepers	15,870	16,808	145,328	8.65	18
19	Laundry	6,581	6,981	50,759	7.27	19
20	Administrator	3,372	2,080	83,949	40.36	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	13,115	14,221	224,747	15.80	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,065	2,188	29,327	13.40	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	236,970	250,126	$ 3,253,892 *	$ 13.01	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$		35
36	Medical Director	Monthly	7,500	5,9,3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	5,667	5,10,3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify) Admin. Consulting		1,510	5,21,3	46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 14,677		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number ManorCare at Peoria # 0027599 Report Period Beginning: 6/1/02 Ending: 5/31/03

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Carol Williams	Administrator	0	$ 83,949
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 83,949

B. Administrative - Other

Description	Amount
Home Office Allocation	$ 389,931
TOTAL (agree to Schedule V, line 17, col. 3)	$ 389,931
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Michael T. Mahoney, Inc.	Legal	$ 769
Grantly Payne and Assoc.	Admin.	541
Miscellaneous	Admin.	42
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 1,352

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 101,402
Unemployment Compensation Insurance	37,265
FICA Taxes	245,378
Employee Health Insurance	251,208
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Appreciation	8,506
401K	6,341
Other Employee Benefits	9,155
Disability Payments	1,365
Employee Uniforms	551
P/R O/H	54
Home Office Allocation	64,813
TOTAL (agree to Schedule V, line 22, col.8)	$ 726,038

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 580
Advertising: Employee Recruitment	5,257
Health Care Worker Background Check	2,105
(Indicate # of checks performed 176)	
Dues & Subscriptions	7,241
Association Dues	5,927
Advertising	38,418
Mktg./Lect.	1,502
Less: Lobbying Expense	(2,117)
Less: Public Relations Expense	(1,502)
Non-allowable advertising	(33,793)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 23,618

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	9,334
Seminar Expense	545
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 9,879

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number ManorCare at Peoria # 0027599 Report Period Beginning: 6/1/02 Ending: 5/31/03

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008
1	N/A		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number ManorCare at Peoria # 0027599 Report Period Beginning: 6/1/02 Ending: 5/31/03

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **IHCA $5,927**

(3) Did the nursing home make political contributions or payments to a political action organization? **Yes** If YES, have these costs been properly adjusted out of the cost report? **Yes, $2,117**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **5-10**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **73,546** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **78,840**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **N/A** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **(337)**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **N/A**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.